Project report:
Duration of elective:
Location: Cambodia Field Research Station, Kep, Cambodia
Affiliation: Center for International Health, University of Toronto.

The pilot program set up by the CIH, University of Toronto at Kep, Cambodia serves to test and teach health intervention strategies in low resource settings. The catchment area covers 16 villages, with 3 PHC(primary health center) and one RH(referral hospital), a population of approximately 34,000 people.
My focus was on the prevalence of HIV in the area, knowledge and attitude of people towards HIV and the strategies available to tackle the fierily increasing epidemic.
Cambodia still has the highest prevalence of HIV in Southeast Asia. According to a survey in 2002, the prevalence in the age group 15-49 years is 2.6% (**HIV** Sero-Surveillance Survey, National Center for **HIV**/AIDS, Dermatology and STDs) which is lower than what it was in 1998. Still an alarming number of people in Cambodia live with HIV/AIDS aka PLHA (people living with HIV and AIDS).

In the municipality of Kep, most of the population consists of farmers and fisherman, who reside in villages. The most effective method to determine the health of the natives is through village outreach programs.
The village set up typically has a village elder who is aware of the number of inhabitants in that particular village, the disease conditions prevalent there and the current interventions in place to tackle those issues. The village elder thus acts as an intermediary between the villagers and the health system.
In a few such tours, it became quite apparent that poverty and lack of knowledge about HIV and AIDS is playing a major role in the persistence of the number of PLHA. The following is a comprehensive summary of my experience in Kep which included working at the PHC, village outreach tours and interaction with CDRCP, a partner with CIH.

1. Unsafe sexual practices:

Most people still engage in unsafe sex practices, The main ones in this area were promiscuous sexual activity, and not using a barrier method of protection. This was mainly due to a lack of knowledge about the transmission of HIV/AIDS or inability to afford protective methods.
The fertility rates were high and pregnant mothers were usually unaware of their HIV status. As such, both the rates of vertical transmission and infant mortality were fairly high. The untoward consequence of pregnancy would usually lead to the diagnosis and identification of another case.

2. Lack of faith in the public health services

The general practice amongst people is to seek medical attention from sources other than the PHC. These caregivers could be traditional healers, midwives, pharmacists or private doctors. It is only after the progression of the primary condition or non responsiveness to the tried treatment that patients will come to PHC or referral hospitals.
This is primarily a reflection of a general shortage of trained personnel, non conducive working hours, geographical distance of the PHC from the village, non availability of health care workers in the evenings and lack of facilities and medications at the PHC.

3. Societal influence

HIV/AIDS continues to be a social taboo. While this practice is slowly changing but one still comes across “HIV villages”. These include a group of HIV positive individuals who have been ostracized

from their family, community and society. These individuals are completely dependent on charitable sources for their basic needs ie food, clothing and shelter. As one can imagine, they live with meager provisions and their primary focus is just as basic as staying alive.

4. Transportation issues

There are only a few centers specialized for HIV testing and offering anti retroviral therapy. Quite obviously, they are overwhelmed with their already existing patient load. Apart from finding a centre willing to accept new cases, the hurdle also lies in the travel required to reach such centers. Most people are unable to afford travel to the local PHC, let alone to the HIV centre. It follows without saying that there is a huge issue around compliance and follow up. Some centers have set up programs where they track the patient and maintain a regular contact, however most governmental programs do not have the infrastructure to support such an intervention. Quite obviously, it is a projection of the number of years of civil war and communal upheaval that the country has suffered.

5. Lack of resources at PHC

There are not enough health personnel to support the functioning of a PHC. Low salaries and lack of incentives in general have led most of the health practitioners to take to private practice. As well, most PHC's are not fully equipped with investigational tools and medications. As far as HIV testing was concerned, there was a shortage of the Rapid HIV test kit, and personnel who would be able to educate around the test and its further implications.

Keeping in mind all the above, the focus of care is shifting towards effective home based strategies. A number of tools have been incorporated as part of the village outreach activities. These include

1. Education :

This is done through posters, interactive sessions, pamphlets, or informal chats. The traditional birth attendant, (usually a female who has been trained to do vaginal deliveries) who is a part of the healthcare team plays a major role in tracking the women who are either of child bearing age or pregnant and educates them about the importance of HIV testing. She will often also be the person administering the test. There builds a strong element of trust between the patient and the TBA. This ensures compliance which is maintained even post partum.

2. Statistics:

The village elder or representative plays a key role in providing the numbers for their respective village. Usually, it is also possible to get a sense of the percentage of individuals who are on therapy and their general state of health etc

3. Building trust:

The continued frequent visits, with the objectives clearly stated and understood by all the villagers, the interactions with villagers of all age groups, the attempts taken by the team to respond to their concerns environment of openness and trust. The number of attendees grew and they were more forthcoming in their problems and doubts.

4. Opportunity to provide general health measures

The visits served as an excellent opportunity to assess the hygiene and living conditions of the villagers in general, offer advice on common problems, and provide a limited health assessment. In collaboration with the village representative, dates for primary vaccinations for all eligible individuals would be set up.

It is a long way to go to set up a health structure for Cambodia where there is health for all. Naturally, one is reminded of the long years of civil war and political upheaval that the country has gone through. Several, governmental and non governmental organizations have stepped in to contribute and bridge the gap, still, a lot remains to be done. Small yet effective interventional measures will be instrumental in seeing continued development.

Dr Savita Kalra
PGY-3, Internal Medicine
University of Toronto